DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244
HEALTH PLAN BENEFITS GROUP

DATE: July 28, 2003

TO: Medicare +Choice Organizations
Medicare Cost Plans
Health Care Prepayment Plans
Evercare, SHMO, and PPO Demonstrations

FROM: Jean D. LeMasurier
Acting Director,
Health Plan Benefits Group

SUBJECT: Model Evidence of Coverage and Disclosure Information, January 1, 2004 through December 31, 2004

I am pleased to provide you with the 2004 Model Evidences of Coverage (EOC) for HMOs, PPOs, and Medicare Cost plans. All organizations must mail the 2004 EOC to all members no later than February 2, 2004. After you have mailed the 2004 EOC to all enrollees, you must mail 2004 EOCs to new members no later than two weeks after the effective date of their coverage.

This year's model EOC includes several improvements over last year's model:

- Last year we provided one HMO model. This year, we are providing three models: one for HMOs, one for PPOs, and one for Medicare Cost plans. Whenever possible, the language in the PPO and Medicare Cost plan models exactly matches the language in the HMO model. (A model for Private Fee-for-Service plans will be provided next year).

- In the PPO and Medicare Cost plan model EOCs, any language that is different from the HMO model (to reflect the uniqueness of the PPOs or Medicare Cost plans) is in blue text for easy reference.

- All instructions to organizations contained within the models are in shaded text for easy reference.

- A red-lined version of the 2004 HMO model EOC, showing changes made from the 2003 model, is available upon request. Requests for this red-lined document may be sent to wburger@cms.hhs.gov.

Please remember that the EOC is not part of the streamlined marketing review process – M+C organizations and Demonstrations must use CMS-approved ACRP (or PBP, for PPO Demonstrations) information in their EOCs.

As stated above, the model EOCs are written for HMOs, PPOs (including PPO Demonstrations), and Medicare Cost plans. All other Medicare health plans and demonstrations that are required to send an EOC to their members (PFFS plans; HCPPs; Evercare, and SHMO Demonstrations) may base the format and organization of their EOC on these models, since they are considered by CMS to be an acceptable format. Of course, these entities must modify the language in their respective EOCs to conform with the statutory and regulatory requirements under which they operate.

Attached for your convenience is a checklist that organizations may use when submitting their EOC for review. One checklist applies to the HMO and PPO model EOCs and one applies to the Medicare cost plan model EOC. Also attached are some additional instructions regarding 10-day marketing review when the organization follows the model EOC without modification, and preparation of the Benefits Chart in Section 4 of the model.

Questions regarding the 2004 model EOCs and the attachments should be referred to your Regional Office.

Thank you,

Jean D. LeMasurier

Attachments:
Additional Instructions
2004 Model HMO Evidence of Coverage
2004 Model PPO Evidence of Coverage
2004 Model Medicare Cost plan Evidence of Coverage
EOC Submission Checksheets

Attachment – Additional Instructions

10-Day Marketing Review

As outlined in Chapter 3, Section 20 of the Medicare Managed Care Manual, Medicare +Choice organizations and Medicare cost plans that follow the model without modification can receive an expedited (10-day) review of their EOC. For the EOC, "without modification" generally means using the terminology in this model verbatim or only making modifications where the model indicates modifications may be necessary.

Throughout the model EOC, we provide areas where the organization must insert plan-specific language or where the organization has the option to customize language to more accurately reflect its plan arrangement. Inclusion of new or modified language in these areas of the EOC will not prevent an organization from receiving the expedited review of its EOC if the organization has otherwise followed the model without modification.

Also, there are locations throughout the EOC where the M+CO may intend to insert information directed at employer group enrollees. Since M+C employer group marketing materials are waived from CMS marketing review, CMS reviewers will not review the employer group-related information in M+C EOCs, and inclusion of such information will not preclude an M+CO from receiving the 10-day review.

M+C organizations, Demonstrations and Medicare Cost plans can also still receive the 10-day review if they modify the following terms in the model to describe their plans and/or plan rules:

- "[Name of organization]," in which the word "we" or "[name of plan]" or "our" is used in its place;
- "[Name of plan]," in which the word "we" or "[name of organization]" or "our" is used in its place;
- "Member," in which the Medicare health plan consistently uses another word (such as "customer" or "enrollee") to describe the member;
- Member Services," in which the Medicare health plan consistently uses another word (such as "Customer Services") to describe member services. In addition, the Medicare health plan may change any use of a departmental name (such as "Medicare Management Department") to refer to the correct name for its organization;
- "Primary Care Physician," in which the Medicare health plan consistently uses another word (such as "Primary Care Provider") to describe the PCP;
- "Evidence of Coverage," in which the Medicare health plan uses a different title for its EOC (such as "Member Handbook");
- "Self refer," in which the Medicare health plan uses the word "direct access" instead;
- "Coverage," in which the Medicare health plan uses the word "care" instead;
- "Provide care," in which the Medicare health plan would instead use the word "arrange care" to more accurately characterize its delivery system;

- **PPO Model EOC – PPO Demonstrations Only:** If appropriate, the term "Preferred Provider Organization and acronym "PPO" can be replaced with "Point of Service plan" or "Point of Sale plan" or "POS plan."
- Any other word/phrase contained in this EOC (such as "plan provider") which is listed in the "Must Use/Can't Use/Can Use" chart in Chapter 3 of the Medicare Managed Care Manual as being another word/phrase that can be used to describe the word/phrase used in this model.

M+C organization and Medicare Cost plan may also still receive 10-day review if it:

- Deletes references throughout the EOC to a drug benefit (other than those drugs covered by Original Medicare), if the Medicare health plan does not offer a prescription drug benefit.
- Adds references to its web site as an additional source of information for a particular topic.
- Excludes a section from the EOC that it instead includes in another publication (such as a Member Handbook). However, this is only allowed for certain sections of the EOC (the right-hand column of attached checklist lists those sections that, according to regulations, must be in the EOC) and only allowed if the Medicare health plan provides the other publication to all members annually and at the time of enrollment (as required at 42 CFR 422.111(a)(3)).
- Excludes the "supplementary" table of contents at the beginning of each section.

Section 4, Benefits Chart

For consistency, the Benefits Chart in Section 4 of the model EOC follows the same order as the Summary of Benefits (SB). The chart is an expanded version of the SB, and you may include more details about covered services than shown in the model language in this section (and still receive 10-day review if you otherwise follow the model without modification).

If you make any additions, deletions, or modifications to the chart, please highlight them for the regional office to aid them in the review of your materials.

In addition:

1. You may include more information about limitations to covered services, either in the chart and/or in the Section on "Exclusions" that follows.
2. You may include plan premium information by either stating the premium prior to the Benefits Chart, or by including a new first row in the Benefits Chart for the plan premium.
3. We encourage you to use the label, "Benefits Chart" for the chart because this label is simpler and more self-explanatory than "Schedule of Medical Benefits," and it tested well with beneficiaries. However, you may use a label other than

"Benefits Chart" if you prefer. If you do use a different label for the chart, you will need to make a number of changes in other sections that refer back to the Benefits Chart in this section.

4. For all chart sections you must identify services that require prior authorization. Do not use asterisks and footnotes for this purpose, because they are hard for some beneficiaries to understand. Instead, use one or more of the following: (a) a note in italics immediately before mentioning the service: "When approved in advance (this service requires prior authorization):" or (b) a note in italics immediately after mentioning the service "(requires prior authorization (approval in advance) to be covered)"; or (c) notes with similar wording that apply to a whole group of services.
5. If you use one EOC for multiple plans, you may create Section 4 as an insert to the EOC. If you use Section 4 as an insert, you should not include specific premiums or cost sharing amounts that would normally be listed in Section 8 of the EOC, but should instead refer the reader to the Section 4 insert for this information.
6. You may list optional supplemental benefits either in the Benefits Chart or in a separate chart, and when doing so, must make it clear if additional premiums are required and must refer readers to the appropriate place for more information.
7. You may include additional categories of benefits not included in the model Benefits Chart (such as dental riders, disease management programs).
8. When a row in the Benefits Chart breaks across two pages, you must repeat the main heading for the row at the top of the continuation page, followed by the words, ", continued". (The chart does not illustrate this rule since it is only model text)
9. The benefits chart must be formatted in a manner that makes a clear link between a specific benefit that is listed in bullet form on the left side of the chart and the information about cost sharing that is listed on the right side.
10. **PPO Demonstrations:** If any of the Original Medicare services you list are only covered in network, clearly indicate that they are not covered out of network.
11. **PPOs:**
    - If you offer benefits for which the coinsurance is the same percentage both in and out of network, you must make it clear that the member responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not the contracted amount.
    - If you offer mandatory supplemental benefits (such as prescription drugs or dental services) limited to in-network providers and facilities, you must specifically explain which benefits are offered at the non-preferred benefit level.